

PRINTED: 08/08/2013
FORM APPROVED

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC57000070	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/03/2013
NAME OF PROVIDER OR SUPPLIER HEALTH MANAGEMENT INSTITUTE/CANOPY (STREET ADDRESS, CITY, STATE, ZIP CODE 13305 MAHAN DRIVE TALLAHASSEE, FL 32308		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETE DATE
C 000	INITIAL COMMENTS A licensure survey was completed There were deficiencies identified.	C 000		
C 042	Operating Standards - Facility Standards Clocks and calendars shall be provided. Ch 65E-9.005(5)(b)9, F.A.C. This STANDARD is not met as evidenced by: Based upon surveyor observation and staff interview, no calendar was made available for facility clients. Findings include: Based upon facility tour at 8:25 AM) there was no calendar posted. At the time of the observation, the facility quality assurance/ compliance supervisor verified there was no calendar posted. She stated there is generally one on the bulletin board but since it was a new month, it had not yet been posted.	C 042	C042: Facility posts calendars ever month for clients to view in the hallway of the house on the bulletin board for clients to view. A calander was posted on prior to the completion of the survey. The inspection on the first day of a new month after a holiday weekend (Labor Day) Therefore our admin staff had been off and No one had posted a new schedule yet. C042: Future: Facility will post schedules prior to the end of the month from now on. This has been put on the Director of Program's Weekly Checklist.	Completion date:
C 046	Operating Standards - Facility Standards and lighting. a. The facility shall provide outside by means of windows, louvers, air conditioners, or in used by children. Windows and doors used for outside shall be operable and shall have screens in good repair. b. All areas of the facility occupied by children	C 046		

AHCA Form 3020-0001

LABORATORY DIRECTIONS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

ONE

BEFE#1

If continuation sheet 1 of 14

Quality Assurance + Compliance 9-18-13
Supervisor

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C 046	Continued From page 1 shall be temperature-controlled in a manner conducive to comfort, safety and privacy. Unless otherwise mandated by federal or state authorities, a temperature of 72 to 82 degrees Fahrenheit during waking hours and 68 to 82 degrees Fahrenheit during sleeping hours shall be maintained in all areas used by children. Cooling devices shall be placed or adjusted in a manner that minimizes drafts. Table fans and floor fans shall have protective covers. c. The facility shall provide sufficient lighting for the comfort and safety of children, including in study areas, and food service areas. d. All incandescent bulbs and fluorescent light tubes shall be protected with covers or shields. e. Hallways to and shall be illuminated at night. f. The facility shall provide egress lighting that will operate if there is a power failure Ch 65E-9.005(5)(b)13, F.A.C. This STANDARD is not met as evidenced by: Based upon surveyor observation, not all lightbulbs were covered for client protection, in one of two client Findings include: Based upon facility tour at 8:25 AM there were four bulbs in the vanity light fixture in the client to These	C 046		
			C046: Light fixture was replaced on Completion Date: and bubs are now enclosed. Picture Attached C046: Future: Have put on the monthly maintenance checklist To observe fixtures every month when the house is walked and Ensure that they are appropriate for clients.	

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C 046	Continued From page 2 bulbs were not covered.	C 046		
C 097	Program Standards - Child's record The provider shall develop an individualized record for each child. The form and detail of the records may vary but shall, at a minimum, include: 1. Identification and contact information, including the child's name, date of birth, Social Security number, gender, race, school and grade, date of admission, and the parent or guardian's name, address, home and work telephone numbers; 2. Source of referral; 3. Reason for referral to residential treatment, e.g., chief complaint, presenting problem(s); 4. Record of the complete assessment; 5. DSM diagnosis; 6. Treatment plan; 7. Medication history; 8. Record of medication administered by program staff, including type of medication, dosages, frequency of administration, persons who administered each dose, and method of administration; 9. Documentation of course of treatment and all evaluations and examinations, including those from other facilities, such as emergency or general hospitals; 10. Progress notes; 11. Treatment summaries; 12. Consultation reports; 13. Informed consent forms; 14. A chronological listing of previous placements, including the dates of admission and discharge, and dependency and delinquency actions affecting the minor's legal status; 15. Written individual education plan for the child, when applicable;	C 097		

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C 097	Continued From page 3 16. The discharge summary, which shall include the initial diagnosis, clinical summary, treatment outcomes, assessment of child's treatment needs at discharge, the name, address and phone number of person to whom the child was discharged and follow-up plans. In the event of a summary shall be added to the record and shall include circumstances leading to the All discharge summaries shall be signed by the clinical or medical director; 17. For out of state children, copies of completed interstate compact ICPC 100A and ICPC 100B forms (2002) and a copy of each Interstate Compact Transmittal Memorandum and any attachments thereto that were sent to the Residential Treatment Center by the department's Interstate Compact on the Placement of Children Office; 18. Documentation of any use of _____ or time out; 19. A copy of each incident report that includes a clear description of each incident; the time, place, and names of individuals involved; witnesses; nature of injuries, if any; cause, if known; action(s) taken; a description of medical services provided, if any; by whom such services were provided; and any steps taken to prevent a recurrence. Incident reports shall be completed by the individual having first hand knowledge of the incident, including paid and volunteer staff, emergency or temporary staff, and student interns; and 20. Documentation that all of the various notices and copies required by these rules were properly given. Records of discharged children shall be completed within 15 business days following	C 097		

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C 097	Continued From page 4 discharge. Chapter 65E-9.006(12)(b) and (c), F.A.C. This STANDARD is not met as evidenced by: Based upon record review and staff interview, the individual client records did not include incidents. This has the potential to impact all facility clients. Findings include: Based upon record review, all facility incident reports (for both the residential treatment center and residential treatment facility) were maintained in a separate book, not associated with any client record. Review of this file revealed that in 8/1/13, client #3 had an incident with attempted self-injury. The facility quality assurance/ compliance supervisor verified in an interview on _____ at approximately 2 PM that there is no separate record keeping for individual incidents.	C 097		
			C097: incident reports are now housed in the client's charts and not in a separate book. They have been filed and will be from this point forward. C097: Future: Notified staff of proper housing of these reports on a go forward	Completion Date: 9/4/2013
C 100	Program Standards - Quality Assurance Quality assurance program. The provider shall develop and follow a written procedure for a systematic approach to assessing, monitoring and evaluating its quality of care and treatment, improving its performance, ensuring compliance with standards, and disseminating results. The quality assurance program shall address and include: (a) Appropriateness of service assignment, intensity and duration, appropriateness of	C 100		

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C 100	Continued From page 5 resources utilized, and adequacy and clinical soundness of care and treatment given; (b) Utilization review; (c) Identification of current and potential problems in service delivery and strategies for addressing the problems; (d) A written system for quality improvement, approved by the provider's governing board that includes: 1. A written delineation of responsibilities for key staff; 2. A policy for peer reviews; 3. A confidentiality policy complying with all statutory confidentiality requirements, state and federal; and 4. Written, measurable criteria and norms assessing, evaluating, and monitoring quality of care and treatment; (e) A description of the methods used for identifying and analyzing problems, determining priorities for investigation, resolving problems, and monitoring to assure desired results are achieved and sustained; (f) A systematic process to collect and analyze data from reports, including, but not limited to, incident reports, grievance reports, department and agency monitoring or inspection reports and self-inspection reports; (g) A systematic process to collect and analyze data on process outcomes, client outcomes, priority issues chosen for improvement, and satisfaction of clients;	C 100			

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C 100	Continued From page 6 (h) A process to establish the level of performance, priorities for improvement, and actions to improve performance; (i) A process to incorporate quality assurance activities in existing programs, processes and procedures; (j) A process for collecting and analyzing data on the use of _____ and _____ to monitor and improve performance in preventing situations that involve risks to children and staff. The provider shall: 1. Collect and regularly analyze, at least quarterly, _____ and _____ data to ascertain that _____ and _____ are used only as emergency interventions, to identify opportunities for reducing the rate and improving the safety of _____ and _____ use, and to identify any need to redesign procedures; 2. Aggregate quarterly _____ and _____ data by all settings, units or locations, including: a. Shift; b. Staff who initiated the procedure; c. Details of the interactions prior to the event; d. Details of the interactions during the event; e. The duration of each episode; f. Details of the interactions immediately following the event; g. Date and time each episode was initiated and concluded; h. Day of the week each episode was initiated; i. The type of _____ used; j. Whether injuries were sustained by the child or staff; and k. Age and gender of each child for which emergency safety interventions had been found necessary. 3. Prepare and submit a report quarterly to the	C 100			

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STREET ADDRESS, CITY, STATE, ZIP CODE

HEALTH MANAGEMENT INSTITUTE/CANOPY

13305 MAHAN DRIVE
TALLAHASSEE, FL 32309

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C 100	Continued From page 7 district/region mental health program office, including the aggregate data and: a. Number and duration of each instance of or experienced by a child within a 12 hour timeframe; b. The number of instances of restraint or experienced by each child; and c. Use of medications as an alternative for or to enable discontinuation of or (k) Analysis of the use of time-out shall be conducted quarterly by the treatment team and shall include: 1. Patterns and trends, for example, by shift, staff present, or day of the week; 2. Multiple instances of time-out within a 12 hour timeframe; 3. Number of episodes per child; and 4. Instances of extending time-out beyond 30 minutes. Chapter 85E-9.006(13)(a), (b), (c), (d), (e), (f), (g), (h), (i), (j), and (k), F.A.C. This STANDARD is not met as evidenced by: Based upon record review and staff interview, there is no comprehensive written procedure for a quality assurance (QA) program. Findings include: Based upon interview with the facility quality assurance/ compliance supervisor (on _____ at approximately 2 PM) there is no comprehensive written procedure for a quality assurance program. Review of the QA documentation documents, items such as adequacy of treatment	C 100	C100: Canopy Cove has revised the QA program to all tie together. Canopy Cove currently has a Health Safety Risk committee, QA committee, Committee, Peer Review committee, and a governing body. Canopy Cove has revised the QA goals to be more comprehensive. In addition the goals are evaluated quarterly and a quarterly report that encompasses the findings of each committee into one report is prepared and provided to CARF (our accreditation board), this system was all already in place but we have tied it together so we ensure that all of the different committees are communication and results tie back to goals that were set at the beginning of the year. The quarterly report will be as comprehensive as possible so we can see our goals come to life. C100: Future: Have updated the spreadsheet that is updated monthly to be more comprehensive.	Completion date: _____

Have to enter a date when meeting happens and
check off when all follow up and reports are completed.

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C 100	Continued From page 8 and incidents are addressed but other areas are not covered in a plan. These include: (a) Appropriateness of service assignment; (b) Identification of current and potential problems in service delivery and strategies for addressing the problems; (c) A systematic process to collect and analyze data from reports, including, incident reports and inspection reports; and (d) A process to incorporate quality assurance activities in existing programs, processes and procedures.	C 100			
C 145	Admission - Admission Packet Admission packet. The provider shall require documentation in the child's admission packet, including: (a) The child's parent or guardian has given expressed and informed consent to treatment; (b) A funding source has been secured for the expected duration of the treatment. If the department is the funding source, there shall be written authorization from the department's mental health program office that approved the funding; (c) The admission packet shall request the identification of a discharge placement for the child upon their completion of treatment and the identification of a contact person who will participate in treatment and discharge planning; (d) The location of the parent or legal guardian or court ordered custodian with responsibility for	C 145			

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C 145	Continued From page 9 medical and dental care, including consent for medical and surgical care and treatment and a statement signed by the parent or legal guardian, and a copy given to the parent or legal guardian, requiring the parent or legal guardian to notify the provider of any change in the parent's or legal guardian's address or telephone number; (e) Order of court commitment or a voluntary placement agreement with parents, guardian, or legal custodian; (f) Arrangements for family participation in the program, including phone calls and visits with the child; (g) Arrangements for clothing and allowances; (h) Arrangements regarding the child leaving the facility with or without the clinical director's consent; (i) Written policies specifying the child's rights as defined in Rule 65E-9.012, F.A.C.; (j) Written acknowledgment of receipt and understanding by the parent or legal guardian and guardian ad litem of the provider's policy regarding the use of _____ or _____ during an emergency safety situation; (k) _____ and _____ evaluations with diagnosis and prior treatment history and psychosocial evaluations, including family relationships, legal status and prior placement history; (l) Educational evaluation, including current	C 145			

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C 145	Continued From page 10 individual education plan and school placement; and (m) Medical information, including a listing of current medications: 1. If a physical examination was not performed within the 90 days prior to admission and documentation of such examination was not provided, a physical examination by a licensed physician shall be initiated within 24 hours of admission; 2. The child's medical history; 3. Written consent from the child's parent or guardian for the provider to authorize routine medical and dental procedures for the child, and to authorize emergency procedures when written parental consent cannot be obtained; and 4. Immunization status and completion according to the U.S. Public Health Service Advisory Committee on Immunization Practices and the Committee on Control of _____ of the American Academy of _____ Chapter 65E-9.006(7), F.A.C. This STANDARD is not met as evidenced by: Based upon client record review and staff interview, the facility did not ensure that one of three current facility clients (#1) had current immunization status information on file. Findings include: Review of the client's record also revealed no immunization status on the client. The facility director of programs stated in an interview (at	C 145	C145: Canopy Cove has made this part of the intake process so it cannot be overlooked by the clinical team when they request prior records. Now, prior to admission, when we email an incoming patient the listing of what to bring on the first day a copy of the immunization record will be listed. Without the immunization records they will not be admitted. See attached sample email that will be sent prior to traveling to Canopy Cove. C145: Future: Has been changed on master document on the server so all future emails will have this requirement	Completion Date 9/10/2013

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C 145	Continued From page 11 approximately 10 AM on they have requested medical records from her primary physician but do not have immunization records.	C 145		
C 146	Admission - Placement Agreement Placement agreement. The provider shall have and make available upon request a written agreement between the provider, the child's parent, guardian, and the department, which shall be kept in the child's file and available for review by the department and agency. The written agreement shall be signed and dated by each of the parties involved. Any revisions or modifications to the written agreement shall be signed and dated. The agreement shall include, at a minimum: (a) The frequency and types of regular contact between the child's family and the provider staff; (b) A plan for sharing information about the child's care and development with the parent, guardian, the guardian ad litem, and the department; (c) The family and the provider's participation in the ongoing evaluation of the child's needs and progress; (d) The designation of staff responsible for working with the child's parent, guardian, guardian ad litem and the organization that signs the placement agreement; (e) Visitation plans for the child's parent, guardian, guardian ad litem or the department. The visitation plans must be flexible to accommodate work and other important schedules of the child's family;	C 146		

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C 146	Continued From page 13 A statement signed by the parent or guardian acknowledging they are aware of their responsibility to keep the provider aware of any changes in their address or telephone number. Findings include: Review of the clients' records (#1, 2, 3) revealed the following information was not available: A written description of complaint procedures, including a method of appeal to the provider management for complaints not resolved to the satisfaction of the child or parent or guardian. The quality assurance supervisor verified in an interview on _____ at 10:55 AM that although the procedure is posted on the wall, it is not provided with the admission paperwork. A statement signed by the parent or guardian acknowledging they are aware of their responsibility to keep the provider aware of any changes in their address or telephone number. An interview was conducted with the facility director of programs at 10 AM on _____. She verified that there is no signed statement (by parent /guardian) acknowledging responsibility to keep provider aware of any changes in contact information.	C 146	C146: We have added acknowledgement of the grievance process to the form they sign at admission. We have attached the revised form for your records. C146: Future: Has been changed on master document on the server so all future forms will have this requirement.	Completion Date:



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2013

Administrator
Health Management Institute/Canopy Cove
13305 Mahan Drive
Tallahassee, FL 32309

Dear Administrator:

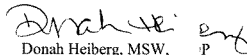
This letter reports the findings of a state licensure survey that was conducted on 2013 by representative(s) of this office. Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies that were identified on the day of the visit.

Please provide a plan of correction to this Field Office, in accordance with enclosed instructions, for the identified deficiencies **within ten calendar days of receipt of this faxed report**. You will not receive a copy of this report in the mail, you will only receive this faxed report. **All deficiencies shall be corrected no later than 2013.**

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at <http://ahca.myflorida.com/Publications/Forms.shtml> as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor(s). Should you have any questions please call me at 850-412-4540.

Sincerely,


Donah Heiberg, MSW, P
Field Office Manager

DH/dh
Enclosure(s)

